IDAHO DEPARTMENT OF HEALTH AND WELFARE
REQUEST TO EXAMINE AND/OR
COPY PUBLIC RECORDS

_____
Date

_____
Name

_____ _____
Mailing Address *Telephone*

_____
Business Name, Affiliation or Representative

DESCRIPTION OF PUBLIC RECORD:

FOR AUTOMATED RECORDS SPECIFY TYPE:

_____

_____
Signature of Requestor

ACKNOWLEDGEMENT OF CUSTODIAN:

_____

_____
Initial if Applicable

Notice: THIS REQUEST IS VOLUMINOUS AND/OR CANNOT EASILY BE LOCATED AND RESPONSE SHALL BE MADE WITHIN TEN DAYS